



# BACK TO BALANCE

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## Welcome to Back to Balance Wellness Center!

### Patient Information:

Thank you for choosing our practice for your health needs. Please complete the attached forms in in. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Date: \_\_\_\_\_ Sex: - Female o Male

Name: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Where do you prefer to receive calls: (please circle) Home Work Mobile Any

Please circle which applies to you: Minor Single Married Divorced Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street City State Zip

Person to contact in case of emergency? \_\_\_\_\_ Phone #: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

### Appointment Confirmation Emails & Newsletter:

Please give us your email address for our office's confirmation list You will receive information regarding your appointments and our practice. We WILL NOT give this information out to anyone.

Email Address: \_\_\_\_\_

### Symptoms:

Reason for visit: \_\_\_\_\_ Date when first appeared: \_\_\_\_\_

Is this condition worsening? (circle) YES or NO What gives you relief? \_\_\_\_\_

### How often your are experiencing these symptoms? (please circle below)

Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (11-25%) Rare (0-11%)

### Which activities are difficult to perform? (please circle all that apply below)

Sitting Standing Walking Bending Lying Down Other